

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155077</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/15/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>45 BEACHWAY DR</b> <b>INDIANAPOLIS, IN 46224</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00181222, IN00183345, IN00183667, and IN00184581.</p> <p>Complaint IN00181222 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00183345 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00183667 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00184581 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 13, 14, 15, 2015</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 100273330</p> <p>Census bed type: SNF: 5 SNF/NF: 102 Total: 107</p> <p>Census payor type: Medicare: 6 Medicaid: 76 Other: 25 Total: 107</p> <p>Sample: 4</p> <p>Lakeview Manor was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155077</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/15/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>45 BEACHWAY DR</b> <b>INDIANAPOLIS, IN 46224</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 16.2-3.1 in regard to the Investigation of Complaints IN00181222, IN00183345, IN00183667, and IN00184581.  Quality review completed 10/19/15 by 29479.	F 000			